Bradley Goldsamt, DDS
WELCOME TO OUR PRACTICE

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Date: _____

Who may we thank for referring you here today? _____

Briefly tell us why you chose our office: _____

Emergency contact : If we need to contact you to reschedule an appointment due to inclement weather, etc., please leave telephone number where you can be reached or a message can be left.

Name: _____ *Telephone #:* _____

Name: _____ *Telephone #:* _____

ABOUT YOUR CHILD:

Name: _____
Male_____ **Female**_____
Birthday: _____
Home Tel. # _____
Home Address:
_____
_____

Child's General Dentist Name:
_____
Address: _____
Tel #: _____
Date of last visit: _____
Who is accompanying your child today?

Name: _____
Relation: _____

Do you have legal custody of this child?
Yes_____ **NO**_____
Parent's Marital Status:
Single____ **Married** _____**Widowed**____
Divorced ____**Separated**_____

PARENT INFORMATION:
Mother:
Name: _____
Employer: _____
Social Security # _____
Date of birth: _____
Work #_____ **Cell #**_____

Father:
Name: _____
Employer: _____
Social Security #_____
Date of birth: _____
Work # _____ **Cell #**_____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____
Relation: _____
Address: _____
_____
Employer: _____
Wk#_____
E-mail Address: _____
_____

INSURANCE: Primary Orthodontic Coverage:
Yes___ **No**___
Insured's Name: _____
Date of birth: _____
Social Security #_____
Relationship to patient: _____
Insured Employer: _____
_____
Insurance Co. Name: _____
Ins. Co. Tel #:_____
Address: _____
_____
Group#, Plan or Local #_____

Secondary Orthodontic Coverage:
Yes___ **No**_____
Insured's Name:_____
Date of Birth:_____
Social Security #_____
Relationship to Patient:_____
Insurance Co. Name: _____
Ins. Co. Tel #:_____
Address:_____
Group#, Plan or Local #_____

Turn over ☺ →→→

Rev 1/13

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Medical History:

Name of child's physician: _____ **Telephone #**_____
Last Visit:_____
Please list all drugs your child is taking:_____
Please list all drugs your child is allergic to:_____
If yes, please list each one :_____
Why did you select our office?_____

Please answer "Yes" or "No"

Y ☐ No ☐ **Artificial heart valves/shunts/patch/catheter**

Y ☐ No ☐ **History of endocarditis of the heart**

Y ☐ No ☐ **Congenital (present from birth) heart condition-other than heart murmur**

Y ☐ No ☐ **Any artificial joints/pins/screws/metal rods or plates in body**

Y ☐ No ☐ **Cardiac surgery-please explain:**_____

Has the patient ever had any of the following diseases or medical problems?

Y	N	**Heart Murmur**	Y	N	**Heart Attack/Stroke**
Y	N	**Allergic To Latex**	Y	N	**Allergic to Metal/Nickel/Jewelry**
Y	N	**Asthma**	Y	N	**Arthritis**
Y	N	**Attention Deficit Disorder (A.D.D.)**	Y	N	**Cancer/Chemotherapy/Radiation**
Y	N	**Convulsions /Epilepsy/ Seizures**	Y	N	**Diabetes**
Y	N	**Fainting**	Y	N	**Hemophilia (Abnormal Bleeding)**
Y	N	**Hepatitis**	Y	N	**High/Low Blood Pressure**
Y	N	**HIV/AIDS**	Y	N	**Psychiatric problems**
Y	N	**Severe /Frequent Headaches**	Y	N	**Sinus Problems**
Y	N	**Tuberculosis**	Y	N	**Allergic to Penicillin or Amoxicillin**

Is the patient currently pregnant? Yes ☐ No ☐

Has the patient ever been hospitalized for any reason? Y ☐ N ☐
If yes, please explain:_____
Please list any medical problems the patient has ever had: _____

Y N Thumb Sucking	**Y N Nail Biting**	**Y N Speech Problems**
Y N Mouth Breather	**Y N Tongue Thrust**	**Y N Nursing Bottle Habits**
Y N Lip sucking/Biting	**Y N Clenching/Grinding Teeth**	

Dental History

Has your child ever been evaluated for orthodontic treatment ?..... Yes ___ No ___
Has your child even been informed of any missing or extra permanent teeth ?.... Yes ___ No ___
Has you child ever experienced pain or discomfort in the jaw joint (TMJ/TMD)? ..... Yes ___ No___
Has your child ever had any injuries to face, mouth, teeth or chin ?. Yes ___ No ___
If yes, please explain: _____
What are the main concerns you would like orthodontics to address? _____
_____

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status:
Signature: *Date:*

Signature on File: I authorize my doctor to act as my agent and authorize my signature to be used in place of the original on insurance claims on behalf of the patient. I also authorize payments directly to the doctor otherwise payable to me:
Signature:_____ **Date**_____

Do not write below this space

I have reviewed the medical/dental information with the patient herein. Initials_____ Date:_____
Doctor's Comments:_____